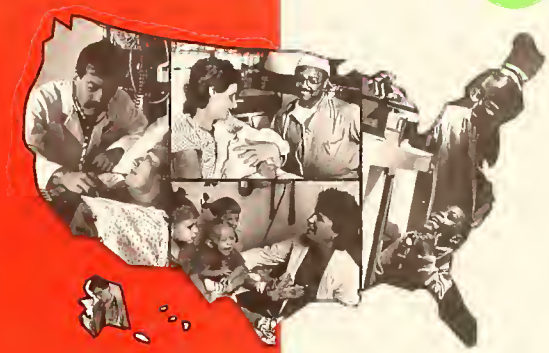
Managed Care *Internal Operations*

Self-Assessment Tool

for Federally Qualified Health Centers



The People We Serve...The People We Are

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DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PRIMARY HEALTH CARE

Public Health Service

Health Resources and
Services Administration
Bethesda MD 20814

Dear Colleagues:

I am pleased to share with you this *Managed Care Internal Operations Self-Assessment Tool.* The Bureau of Primary Health Care (BPHC) is committed to increasing access to primary health care and improving the health status of underserved people. As the aggressive movement toward managed care in the United States expands to these patients, Bureau programs must strive to provide health care services to the underserved in a changing, competitive marketplace. Community and Migrant Health Centers, Public Housing and Homeless grantees, as well as Rural Health Clinics, all Federally-Qualified Health Centers (FQHC), are faced with this challenge.

Two factors make it increasingly important for Bureau programs to consider involvement in managed care:

- Medicaid managed care continues to expand, placing greater demands on health centers to serve existing Medicaid patients who require a broad range of enabling and culturally sensitive services.
- Health care reform at the national and state levels relies on managed care to assure access, manage costs and provide comprehensive services.

Are you ready as an FQHC to participate in managed care? The Bureau has designed this self-assessment tool to assist you in conducting an evaluation of your operational readiness to contract for managed health care and your capacity to handle risk in a managed care setting. The tool was designed with the assistance of experts in managed care and FQHC operations.

I hope you will find this tool helpful in your efforts to participate in the managed care marketplace.

Sincerely,

Marilyn H. Gaston, M.D.
Assistant Surgeon General

Acknowledgments

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Table of Contents

	Intraductian	vi
	Readiness Checklist	**viii**
I.	Baard af Directars and Management	1
II.	Health Care Delivery System and Clinic Management	7
III.	Financial Management	21
IV.	Management Infarmatian System	27
V.	Quality Assurance and Utilizatian Management Plan	37
VI.	Facility	45
VII.	Cancluding Strategic Questians	49
	Appendix 1: Managed Care Glassary	53
	Appendix 2: Resaurce Materials	59

Introduction

This self-assessment tool is useful to both FQHCs which are currently involved in managed care as well as those considering a contract or other managed care arrangements such as network development.

- ✔ For programs already providing care in a managed care setting, this tool will help you identify areas where change can result in improved experience in the utilization, cost and quality of services rendered.
- ✔ For programs considering involvement in managed care, this tool will assist you in identifying operational areas which require further development prior to managed care involvement.
- ✔ For all programs, this assessment tool will help you define the unique qualities you offer managed care plans and the strengths you bring to the contract negotiation and network development process.

It is anticipated that all sections of the self-assessment tool will not be applicable to every program. Sections and questions which are not applicable to

you should not be utilized. Further, programs with multi-sites may have some sites involved in managed care programs while other sites are not. In this case, separate assessments should be conducted of those sites engaged in managed care operational activities versus sites which may be involved in the future.

Senior management staff members who are responsible for health center operations, provider activities, finance and information systems should be involved in using this tool. In addition, the Board of Directors is encouraged to be actively involved in all assessment activities, and in particular in several Board related assessment areas, to review the assessment summary and to approve the resultant plan of action.

This self-assessment tool provides a "snap-shot" of your strengths and weaknesses in the area of managed care operations at a particular point in time. Through the exercise of completing this tool you will identify areas requiring further development and design a plan of action to carry out the desired changes. Since the results of the tool are predicated on your current circumstances, you should consider repeating the exercise on a regular basis as your local circumstances change and you are faced with continuing managed care developments. In this way, you can regularly assess progress in areas where weaknesses were previously identified and identify new areas requiring additional attention.

This assessment tool is designed to complement the *Managed Care Market Area Self-Assessment Tool*. The results of the market area self-assessment identify trends in your marketplace and key players in the managed care arena and provide a means to evaluate options for participating in managed care networks. The results of the internal self-assessment document your operational readiness to contract for managed care and your capacity to handle risk in a managed care setting. This assessment process is solely for use by the FQHC and is *not* a component of any federal review process.

You should begin this assessment by completing the **Readiness Checklist**, which immediately follows on page viii. The Readiness Checklist identifies key issues which will be of interest to your potential managed care partners. In addition to the readiness

checklist, the ***Managed Care Internal Operatians Self-Assessment Toal*** consists af the fallawing seven sectians:

1. Board af Directars and Management
2. Health Care Delivery System and Clinic Management
3. Financial Management
4. Management Information System
5. Quality Assurance and Utilizatian Monagement Plan
6. Facility
7. Concluding Strategic Questians

Each sectian includes an intraductary paragraph, a recommendatian for staff to complete the sectian, a series af questians and an actian plan. It is recagnized that in any given pragram staff members ather than thase recammended may be mare appropriate based an the unique staffing patterns of each BPHC program.

Twa oppendices ore pravided far yaur reference. **Appendix 1** is a glossory af key manoged care terms. **Appendix 2** provides a list af resaurce materiols which are available, os needed.

Readiness Checklist

Let's briefly assess yaur readiness far managed care. Fallawing are key issues which will be af interest ta yaur potential managed care partners.

- ❑ Our Baard and stoff are knawledgeable abaut managed care cancepts and are cammitted ta participating in managed care.
- ❑ A seniar level management staff persan is designated ta caardinate aur managed care activities.
- ❑ Our physicians have admitting privileges at lacal haspitals, are Baard certified ar Baard eligible, have current and adequate malpractice pratectian and have a current medical license.
- ❑ A pravider caverage system is in effect seven days a week, 24 haurs a day.
- ❑ We have an effective appaintment system which meets reasanable standards far access.
- ❑ We have the capacity far exponsian ta accammadate additianal members.
- ❑ Our financial and accaunting systems are based an accrual accaunting and can track the casts and utilizatian af capitated services.
- ❑ We have adequate and timely data, and staff has the capability ta analyze reparts and identify adverse trends.
- ❑ We have a written quality assuranca and utilizatian management plan which includes palicies ond pracedures far managed care activities.
- ❑ Our patients are satisfied with our providers and the services they receive fram our center.

Haw did yau fare on this brief readiness checklist? The sectians that fallaw will help yau laak at yaur center(s) in further detail. We will ga beyand these first issues ta all areas of your aperatian that will be affected by managed care.

BOARD OF DIRECTORS AND MANAGEMENT

Board and staff must be knowledgeable about managed care concepts as well as being committed to participation in managed care. You need to assess the capabilities and responsibilities of your Board of Directors and Management staff to operate in a managed care environment.

TO BE COMPLETED BY:

The Executive Committee of the Board and Senior Management Staff

Board of Directors

1 Invalvement in managed care may require yaur Board of Directars ta cansider new market, financial, health care and legal cancepts and ta evaluate related dacuments. Ta fulfill these respansibilities, daes yaur Baard need additianal expertise in any af the fallawing areas?

- ❑ Marketing
- ❑ Finance
- ❑ Health care
- ❑ Legal
- ❑ Public relatians
- ❑ Other_____

2 The review of key documents and reports by your Board of Directors is important to your success in managed care. Which of the following documents and reports are reviewed and approved by your Board? (Check all that apply.)

Table 1. Board of Directors' Documents & Reports

Reports	*Review*	*Approve*	*Not Applicable*
Managed Care Contracts	❑	❑	❑
Annual operating budget	❑	❑	❑
Financial Reports	❑	❑	❑
Utilization and Cost Reports	❑	❑	❑
Utilization Management Plan	❑	❑	❑
Quality Assurance Plan and Reports	❑	❑	❑
Patient and Provider Grievance Reports	❑	❑	❑
Other _____	❑	❑	❑

**The MIS section provides additional reports that you may want your Board to review.*

Management

3 Management staff need to have the capability to manage operations related to managed care. It is also helpful to have one person coordinating your managed care activities. Who on your staff has the capability in and/or responsibility for each of the following areas?

Table 2. Management Staff Capability in/Responsibility for Managed Care Operations

Operational Area	*Management Staff Member*						
	Executive Director	Financial Director	MIS Director	Clinical Director	Site Director	Other Staff	Specify
Managed Care Coordination	❑	❑	❑	❑	❑	❑	_____
Capitation Rate Evaluation	❑	❑	❑	❑	❑	❑	_____
Information Needs and MIS	❑	❑	❑	❑	❑	❑	_____
Delivery System Design	❑	❑	❑	❑	❑	❑	_____
Provider Education as Gatekeepers	❑	❑	❑	❑	❑	❑	_____
Utilization and Cost Controls	❑	❑	❑	❑	❑	❑	_____
Quality Assurance	❑	❑	❑	❑	❑	❑	_____

4 Baard members and seniar staff must be knawledgeable abaut key managed care cancepts such as capitatian, primary care gatekeeper and financial risk. What managed care training pragrams have yaur Baard members and seniar staff attended within the last twa years?

Table 3. Managed Care Training Programs Attended

Program	*Participants*

ACTION PLAN

The following actions are necessary to ensure the Board of Directors and Management Staff are prepared to carry out their responsibilities related to our managed care activities:

1. The Board of Directors needs to add members with the following expertise:

_____

_____

_____.

2. The Board should review and approve the following additional reports:

_____

_____

_____.

3. Based on our responses in **Table 2,** the following management staff should assume responsibility for the key managed care operational areas:

_____

_____

_____.

4. Based on our responses in this section, additional training is needed for our Board members and management staff to be effective in managed care:

Board/Staff member	Training needed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Based on the Board and management review of the final action plan, technical assistance and/or consultative services are needed in the following areas:

_____

_____

_____.

HEALTH CARE DELIVERY SYSTEM AND CLINIC MANAGEMENT

Depending an the specific cantractual arrangements, managed care plans will expect yau ta meet the fallawing health care requirements:

- Pravide preventive and primary care services
- Arrange far appropriate specialty, ancillary and haspital services
- Ensure an effective appaintment system
- Ensure cantinuity af care
- Accammadate membership grawth
- Pravide 24-haur, 7 days-per-week caverage
- Caaperate with Quality Assurance activities

TO BE COMPLETED BY:

The Clinic Directar and Site Manager(s)

Primary, Specialty, Ancillary & Hospital Services

1 In **Table 4** below you should evaluate your health care delivery system and compare it to the managed care plan's participating provider network. Indicate with an **"x"** in column 1 whether you directly provide primary, specialty, ancillary and hospital services or with an **"x"** in column 2 if you have made arrangements for these services. In column 3, indicate with an **"x"** whether the managed care plan will require you to use their provider network. In the **Financial Management** section which follows, you should analyze which of those health care services you have direct management and fiscal control over. It is these for which you can consider assuming financial risk.

Table 4. Covered Services

	Covered Services	*FQHC Provides* (column 1)	*FQHC Has Arranged* (column 2)	*Managed Care Plan Provider Network* (column 3)
PRIMARY CARE	Pediatrics			
	Adult Medicine			
	OB/GYN			
SPECIALTY CARE	Cardiology			
	Orthopedics			
	Dermatology			
	Ophthalmology			
	Allergy			
	Pulmonary			
	Other _____			

Table 4. Covered Services (cont.)

	Covered Services	FQHC Provides (column 1)	FQHC Has Arranged (column 2)	Managed Care Plan Pravider Netwark (column 3)
ANCILLARY SERVICES	Laboratory			
	Diagnostic Radiology			
	Mammography			
	Pharmacy			
	Optometry			
	Short-term Home Health			
	Therapy (Occupational, Physical, etc.)			
	Outpatient Mental Health			
	Substance/Alcohol Abuse			
	Podiatry			
	Durable Medical Equipment			
HOSPITAL SERVICES	Pediatrics			
	Obstetrics			
	Medical/Surgical			
	Mental Health			
	In & Out Surgery			
	Emergency			

2 Managed care plans will require each enrolled member to select a primary care physician.

	Yes	No
• Do your patients currently select a primary care provider?	❑	❑
• Do you have a policy that a patient is always given an appointment with their primary care provider?	❑	❑
• Do you have a system for changing primary care providers?	❑	❑
• Do you have a process to monitor how patients access services if they are unable to see their primary care provider?	❑	❑
• What percentage of the time are patients unable to see their primary care provider? ____%		

3 Most managed care plans will require authorization of specialty referral, ancillary and/or hospital services either by the primary care physician and/or the managed care plan.

	Yes	No
• If you are involved in managed care do your primary care physicians provide prior authorization for:		
Specialty services?	❑	❑
Ancillary services?	❑	❑
Hospital services?	❑	❑
• Do you require your referral physicians to provide a written consultation to the primary care physician?	❑	❑
• Do your primary care providers understand their responsibilities for serving as gatekeepers?	❑	❑

Preventive and Support Services

4 Managed care plans require you to provide key preventive health care services. These are services which FQHCs normally provide and should be viewed as a strength in your managed care contract negotiations.

Are the preventive and support services in **Table 5** available at the health center?

Table 5. Preventive and Support Services Available at Health Center

	Yes	No		Yes	No
Voluntary family planning services	❑	❑	EPSDT	❑	❑
Well child and adolescent care	❑	❑	Health Education	❑	❑
Periodic health evaluation for adults	❑	❑	Nutrition Counseling*	❑	❑
Well women's care	❑	❑	Case Management*	❑	❑
Pediatric and adult immunizations	❑	❑	Transportation*	❑	❑
Preventive Dental	❑	❑	Translation *	❑	❑

**These services may not be covered benefits of the managed care plans*

Provider Productivity and Patient Capacity

5 Managed care plans develop their capitation rates based on average costs and expected utilization patterns. Therefore, you should evaluate your capacity for expansion to accommodate additional members.

Your costs and patient capacity are directly affected by the productivity of your providers. To evaluate your provider productivity and excess patient capacity, complete **Table 6** based on data from the last twelve months of operation. (Follow the instructions on page 13).

Table 6. Selected Provider Productivity and Health Center Capacity

	(a) FTEs	(b) Actual annual visits per specialty	(c) Average annual visits per FTE (b / a)	(d) Standard annual visits per FTE	(e) Standard annual visits per specialty (a x d)
Pediatrics					
Internal Medicine					
Family Practice					
Obstetrics/Gynecology					
Total					

	(f) Add'l visit capacity per year (e – b)	(g) Productivity per FTE (c / d)	(h) Standard # primary care visits per patient per year	(i) Actual patients per year (b / h)	(j) Standard patient capacity per year (e / h)	(k) Add'l patient capacity per year (j – i)
Pediatrics						
Internal Medicine						
Family Practice						
Obstetrics/Gynecology						
Total						

Table 6 Instructions

a) Insert the number of Full-Time Equivalent (FTE) providers in each medical specialty area.

b) Insert the total number of annual visits for each medical specialty area.

c) Divide the number of visits in each medical specialty by the number of FTEs in that specialty **(b / a)**. This will give you the average annual visit rate for each FTE in that specialty.

d) Insert a standard annual primary care visit rate for each specialty, (e.g., MGMA 1992 Cost Survey: Pediatrics–5,374; Internal Medicine–3,695; Family Practice–5,029; Obstetrics/Gynecology–3,530. Public Health 1985: Pediatrics–5,910; Internal Medicine–3,130; Family Practice–5,500; Obstetrics/Gynecology–5,350; or another standard of your choice).

e) Multiply the FTEs by the standard annual visit rate **(a x d)**. This will give you the standard annual primary care visits per specialty per year.

f) Calculate whether you have additional visit capacity in any specialty area and in total **(e – b)**.

g) Calculate the provider productivity per FTE based on the standard **(c / d).**

h) Insert your own experience/standard for the number of primary care visits per patient per year. (e.g., pediatrics: 4.5–4.8 visits per year; internal medicine: 3.2–3.3 visits per year)

i) Calculate the number of actual patients per year **(b / h).**

j) Using your standard number of primary care visits per patient per year, calculate how many patients you would have based on standard rates **(e / h).**

k) Calculate whether you have additional patient capacity in any specialty area and in total **(j – i).**

Physician Hospital Admitting Privileges

6 Most managed care programs will want your physicians to have admitting privileges at their participating hospitals. Complete **Table 7** to evaluate your physicians' hospital admitting privileges.

	Yes	No
7 **a)** Do your primary care physicians have hospital privileges?	❑	❑
b) If yes, are the primary care physicians expected to follow their patients in the hospital?	❑	❑
c) If no to either (a) or (b), do you have a procedure to communicate information about a patient's hospital care with the primary care physician?	❑	❑

Table 7. Physician Hospital Admitting Privileges

FQHC Physician Name	*Hospital*	*Hospital*	*Hospital*
Dr. _____	_____	_____	_____
Dr. _____	_____	_____	_____
Dr. _____	_____	_____	_____
Dr. _____	_____	_____	_____
Dr. _____	_____	_____	_____
Dr. _____	_____	_____	_____

Health Center Hours and 24-Hour, 7 Day per Week Coverage

8 Most managed care programs will require your center to be open a minimum number of hours. In addition, the plans will require your health center to have a 24-hour, seven day per week coverage system to decrease medically unnecessary emergency room utilization and to provide accessible care.

	Yes	No
• Does the number of hours your health center is open meet the requirements of the managed care plan?	❑	❑
• Does your health center have a 24-hour coverage system which includes access to a provider when the health center is not open?	❑	❑
• Is there a system set up to advise the primary care physician of emergency services provided to his/her patients as well as the information from the 24-hour coverage system if he/she does not take the call?	❑	❑
• Is the information from the 24-hour coverage system entered in the patient's medical record?	❑	❑

Appointment System

9 Managed care plans will evaluate your appointment system including the amount of time it takes to get an appointment and what kind of support you provide to assist your patients.

	Yes	No
• Are your appointments provider and time specific?	❑	❑
• For a patient who has an appointment, is the average waiting time to see a provider less than 20 minutes from the time the patient registers at the center?	❑	❑

- Complete **Table 8** to compare your actual appointment waiting time to an example from a managed care contract. Waiting time for appointments may vary for pediatric, prenatal and adult patients.

Table 8. Waiting Time for Appointments

	Waiting Time for Appointment	
Medical Problem	Actual	Example
Physicals, scheduled preventive care		6 weeks
Non-urgent symptomatic office		2 weeks
Urgent care		24 hours
Emergency care		Same day*

**physician response within 30 minutes*

	Yes	No
• Da health center suppart staff moke arrongements far appaintments with:		
Specialists?	❑	❑
Ancillary services?	❑	❑
Haspital autpatient services?	❑	❑
• Do patients receive verbal and/or written reminders af their upcaming health center appaintments?	❑	❑
• Is there a system for fallawup far missed appaintments?	❑	❑

Telephone and Reception

10 Telephane and reception palicies and pracedures will be evaluated by managed care plons to determine your respansiveness ta patients. It will alsa be impartant far telephane and receptian staff ta be trained in ond knowledgeable obout managed care palicies and pracedures.

	Yes	No
• Are there written telephane palicies and pracedures far triaging patients ta a physician ar a nurse?	❑	❑
• When a patient calls do they get o respanse within twa minutes?	❑	❑
• Is an emergency telephane number automatically pravided during affico haurs if a patient is put on hald ar connected ta a vaice mail system?	❑	❑
• Are receptian desk palicies ond pracedures in place:		
Ta identify patients by payar?	❑	❑
Ta callect necessary capoyments?	❑	❑
To identify referral praviders based an patient coverage?	❑	❑
• If the health center is invalved in managed care, have training pragrams been conducted far staff ta familiarize them with health center and managed care palicies and pracedures?	❑	❑

ACTION PLAN

The following actions are necessary to restructure our health care delivery system and clinic management to meet the demands and requirements of managed care.

1. To meet the requirements of our managed care contract(s), we need to provide or make arrangements for the following covered services (For services you do not provide, did you identify a potential partner in **Table 15** of the *Managed Care Market Area Self-Assessment Tool*?):

Primary Care

_____ _____
_____ _____
_____ _____
_____ _____

Specialty Care

_____ _____
_____ _____
_____ _____
_____ _____

Ancillary Care

_____ _____
_____ _____
_____ _____
_____ _____

Hospital Services

_____ _____
_____ _____
_____ _____
_____ _____

2. To meet the requirements of our managed care contract(s), we will need to refer to the plan's participating providers for the following services:

_____
_____
_____
_____
_____
_____.

3. Our primary care physician selection and appointment system needs to be improved as follows:

_____

_____

_____.

4. Our specialty physician referral and authorization process needs to be improved as follows:

_____

_____

_____.

5. The following physicians need to obtain admitting privileges at these hospitals. (Compare information to the hospital affiliated with your potential managed care plan in **Table 17** of the *Managed Care Market Area Self-Assessment Tool.*):

Physician	Hospital
_____	_____
_____	_____
_____	_____

6. Our provider productivity should be addressed in the following specialities:

_____

_____

_____.

7. We need to develop additional capacity for managed care patients in the following specialities:

_____

_____

_____.

8. The following support systems, policies and procedures need to be revised to meet the demands of managed care, i.e. 24-hour coverage, appointments, telephone, reception, other:

System/policy/procedure	Change
_____	_____
_____	_____
_____	_____
_____	_____

FINANCIAL MANAGEMENT

Bureau programs shauld anly assume financial risk far those health care services far which they have direct management and fiscal cantral. Yaur financial management capabilities are extremely impartant ta a successful experience with managed health care. Yau will need ta have aperatianal systems in place including an accrual accaunting system, ta manage and reduce casts.

Key financial management areas which require assessment include:

- Revenue saurces
- Financial risk
- Financial and accaunting systems
- Capitatian
- Pravider reimbursement

TO BE COMPLETED BY:

The Directar af Finance

Revenue

1 Complete **Table 9** based on the last twelve months of operation (reference your most recent BCRR for this data). If a significant percentage (e.g., 15%) of your revenue is currently or will be derived from prepaid patients, it is important to take the steps necessary to operate your health center effectively in a managed care environment.

Table 9. Revenue Sources

	Annual Revenue	
Payor/Grants	Total Annual Revenue	Percent of Total
Medicaid Prepaid	$	
Medicare Prepaid	$	
Other Prepaid	$	
Subtotal prepaid revenue	$	
Medicaid Fee-for-Service	$	
Medicare Fee-for-Service	$	
Commercial Insurance	$	
Self Pay	$	
Grant Sources (e.g., 329, 330, 340)	$	
Other	$	
Subtotal	$	
Total Revenue	**$**	**100%**

Financial Risk

2 Under your current or proposed managed care contract, you should accept financial risk only for those services for which you have direct management and fiscal control. Complete **Table 10** to determine those services for which you have control and may accept risk and those services for which you have no control and should not accept risk.

Table 10. Financial Risk Assessment

		Management/Financial Control-Risk Acceptable		*No Management/Financial Control-Risk Unacceptable*	
	Financial Risk Areas	FQHC staff provide	FQHC staff authorize, refer	FQHC staff refer only	Services not available
PRIMARY CARE	Pediatrics	❑	❑	❑	❑
	Adult Medicine	❑	❑	❑	❑
	OB/GYN	❑	❑	❑	❑
SPECIALTY CARE	Cardiology	❑	❑	❑	❑
	Orthopedics	❑	❑	❑	❑
	Dermatology	❑	❑	❑	❑
	Ophthalmology	❑	❑	❑	❑
	Allergy	❑	❑	❑	❑
	Pulmonary	❑	❑	❑	❑
	Other _____	❑	❑	❑	❑

Table 10. Financial Risk Assessment (cont.)

		Management/Financial Control-Risk Acceptable		*No Management/Financial Control-Risk Unacceptable*	
	Financial Risk Areas	FQHC staff provide	FQHC staff authorize, refer	FQHC staff refer only	Services not available
ANCILLARY SERVICES	Laboratory	❑	❑	❑	❑
	Mammography	❑	❑	❑	❑
	Pharmacy	❑	❑	❑	❑
	Optometry	❑	❑	❑	❑
	Short-term Home Health	❑	❑	❑	❑
	Therapy (Occupational, Physical, etc.)	❑	❑	❑	❑
	Outpatient Mental Health	❑	❑	❑	❑
	Substance/ Alcohol Abuse	❑	❑	❑	❑
	Podiatry	❑	❑	❑	❑
	Durable Medical Equipment	❑	❑	❑	❑
HOSPITAL SERVICES	Pediatrics	❑	❑	❑	❑
	Obstetrics	❑	❑	❑	❑
	Medical/Surgical	❑	❑	❑	❑
	Mental Health	❑	❑	❑	❑
	In & Out Surgery	❑	❑	❑	❑
	Emergency	❑	❑	❑	❑

Financial and Accounting System

3 Your financial and accounting system must be designed to adequately support managed care financial activities, specifically to provide information to manage and control your capitated health care activities. If you are involved in prepayment, does your system include the following:

	Yes	No
• Segregated prepaid and fee-for-service accounting centers?	❑	❑
• Tracking costs of capitated services?	❑	❑
• Tracking costs of non-capitated services?	❑	❑
• Billing capabilities for non-covered services and copayments?	❑	❑
• Accrual accounting?	❑	❑

Capitation

4 If you are involved in a capitated arrangement, you will need to have information to support initial capitation negotiations and to regularly monitor the adequacy of the capitation revenue. Do you have the following cost information:

	Yes	No
• Cost of each covered service included in the capitation?	❑	❑
• Cost per fee-for-service patient visit?	❑	❑
• Cost per prepaid patient visit?	❑	❑
• Cost of non-covered services?	❑	❑

Provider Reimbursement

5 In order to encourage your providers to improve their productivity and to decrease the utilization and cost of services rendered to prepaid patients, have you considered any performance incentives (e.g., bonuses)? ❑ ❑

ACTION PLAN

The following actions need to be token to limit our financiol risk to only those service for which we hove direct monogement ond fiscol control, to improve our monogement of the utilization ond cost of services rendered to prepoid patients, ond to trock prepoyment finoncial performonce ogoinst budget.

1. Limit our finonciol risk to the following services:

_____

_____

_____

_____

_____

_____.

2. Revise our finoncial ond occounting system as follaws:

_____

_____

_____

_____

_____

_____.

3. Produce the following cost informotion to negotiate ond monitar the copitotian:

_____

_____

_____

_____

_____

_____.

4. Consider the following performonce incentives with Heolth Center providers:

_____

_____

_____

_____.

MANAGEMENT INFORMATION SYSTEM

To succeed in o monoged care environment, you must hove oppropriote doto which is formotted in usoble reports ond is ovoiloble in o timely monner. Mony of the reports will be provided by the monoged core plon(s). Other reports will be prepored internolly by your stoff. Just os importont, your stoff must hove the copobility to onolyze these reports, identify odverse trends ond recommend corrective oction.

The reports foll into four moin cotegories:

- Membership
- Copitotion
- Aggregote utilizotion
- Individuol provider utilizotion

TO BE COMPLETED BY:

The MIS Director or the stoff member responsible for this oreo

Membership

1 Your health center will be selected as the primary care provider by managed care members. To carry out your responsibilities in a managed core plan and to limit your liability for disenrolled patients, you need an accurate and timely membership report from the managed care plan(s). Can you get the data in **Table 11** from the managed care plan(s)?

Table 11. Membership Report

Data Elements	*Data Provided By*		*Data Available to Health Center*		
	Health Center	Managed Care Plan	Yes	No	Don't Know
Ending membership (last month)		✓	❑	❑	❑
New Additions		✓	❑	❑	❑
Terminations		✓	❑	❑	❑
Beginning Membership (this month)		✓	❑	❑	❑

You should also receive a report from the managed care plan listing all the patients who have selected your health center as their primary care provider. If this list does not designate the patient's primary care physician, this should be done by the health center.

Capitation

2 If you have a capitation arrangement with a managed care plan, you need to regularly compare the capitation revenue with your cost of providing the capitated services. The Capitation Profile Report in **Table 12** should be prepared at the beginning of each month for each payor group (i.e. Medicaid, Medicare, commercial). Is the data in **Table 12** available from your information system and from the managed care plan(s)?

Table 12. Capitation Profile Report

Data Elements	*Data Provided By*		*Data Available to Health Center*		
	Health Center	Managed Care Plan	Yes	No	Don't Know
Member months		✓	❑	❑	❑
Capitation revenue pmpm		✓	❑	❑	❑
Copayment revenue pmpm	✓		❑	❑	❑
Cost of capitated services	✓		❑	❑	❑
FQHC gain or loss pmpm*	✓		❑	❑	❑

**The gain pmpm represents the contribution margin (gross profit) available to support administrative costs*

Aggregate Utilization and Cost

3 Health care utilization and cost, on an aggregate basis, needs to be monitored monthly. The aggregate primary care and speciality/ancillary reports provide an overview of the utilization and cost patterns for all patients by payor group and should be used to compare actual to projected utilization and cost. All FQHCs should review primary care service utilization and cost. Do you have the data available in **Table 13(a)?**

Table 13(a). Primary Care Aggregate Utilization and Cost Report

	Data Elements	Data Provided By: Health Center	Data Provided By: Managed Care Plan	Data Available to Health Center: Yes	Data Available to Health Center: No	Data Available to Health Center: Don't Know
PRIMARY CARE	Number of member months		✓	❑	❑	❑
	Number of primary care visits	✓		❑	❑	❑
	primary care visits pmpy	✓		❑	❑	❑
	Total primary care costs	✓		❑	❑	❑
	Cost per primary care visit	✓		❑	❑	❑
	Primary care capitation pmpm		✓	❑	❑	❑
	Cost of primary care pmpm	✓		❑	❑	❑

If you are at risk only for primary care services, the managed care plan should provide you with a report on the total cost and utilization of specialty and ancillary services for your membership. However, if you are capitated for these services you will require a more detailed level of data. Can you obtain the data in **Table 13(b)** from the managed care plan(s)?

Table 13(b). Specialty/Ancillary Aggregate Utilization and Cost Report

		Data Provided By		Data Available to Health Center		
	Data Elements	Health Center	Managed Care Plan	Yes	No	Don't know
SPECIALTY CARE	Number of paid referrals		✓	❑	❑	❑
	Referral visits pmpy		✓	❑	❑	❑
	Referral visits per referral		✓	❑	❑	❑
	Total specialty cost		✓	❑	❑	❑
	Amount per paid referral		✓	❑	❑	❑
	Specialty capitation pmpm		✓	❑	❑	❑
	Cost of specialty care pmpm		✓	❑	❑	❑
ANCILLARY SERVICES	Number of paid referrals		✓	❑	❑	❑
	Ancillary visits pmpy		✓	❑	❑	❑
	Total ancillary cost		✓	❑	❑	❑
	Cost per paid referral		✓	❑	❑	❑
	Ancillary capitation pmpm		✓	❑	❑	❑
	Cost of ancillary services pmpm		✓	❑	❑	❑
EMERGENCY	Number of paid emergency service visits		✓	❑	❑	❑
	Total emergency room cost		✓	❑	❑	❑
	Cost of emergency room pmpm		✓	❑	❑	❑

Assuming you are not at risk for inpatient services, hospital information will be limited to the names of patients admitted and discharged from each hospital as in the Inpatient Hospital Log below. If you desire specific inpatient data for analysis (i.e. total admissions, cost per admission, inpatient cost pmpm, etc.), this can be requested from the managed care plan. Is the inpatient data in **Table 13(c)** provided by the managed care plan(s)?

Table 13(c). Inpatient Hospital Log

Data Element	Data Provided By		Data Available to Health Center		
	Health Center	Managed Care Plan	Yes	No	Don't know
List of patients admitted and discharged by hospital		✓	❑	❑	❑

Individual Provider Utilization and Cost

4 Individual provider profiles provide utilization and cost patterns for each of your primary care providers. These profiles should be compared with other physicians in the same specialty, with the aggregate utilization reports and with the managed care plan's utilization and cost projections to evaluate the appropriateness of the provider's patterns. Can you obtain this information from your own database and from the managed care plan(s) where indicated in **Table 14(a)**?

Table 14(a). Individual Primary Care Provider Utilization Profile

	Data Element	Data Provided By: Health Center	Data Provided By: Managed Care Plan	Data Available to Health Center: Yes	Data Available to Health Center: No	Data Available to Health Center: Don't know
PRIMARY CARE	Hours worked	✓		❑	❑	❑
	Number of primary care visits	✓		❑	❑	❑
	Primary care visits/hour	✓		❑	❑	❑
	Number of visits/primary care patients/year	✓		❑	❑	❑
SPECIALTY CARE	Number of paid referrals		✓	❑	❑	❑
	Number of paid referral visits		✓	❑	❑	❑
	Referral visits per referral		✓	❑	❑	❑
	Total specialty expenses		✓	❑	❑	❑
	Amount per paid referral		✓	❑	❑	❑
ANCILLARY	Number of paid ancillary referrals		✓	❑	❑	❑
	Total ancillary expenses		✓	❑	❑	❑
	Cost per ancillary referral		✓	❑	❑	❑
HOSPITAL *	Number of admissions		✓	❑	❑	❑
	Number of inpatient days		✓	❑	❑	❑
	Inpatient costs		✓	❑	❑	❑
	Average length of stay		✓	❑	❑	❑
	Cost per admission		✓	❑	❑	❑
	Number of paid emergency room visits		✓	❑	❑	❑

** Authorized by primary care provider*

Assuming you are not at risk for specialty services, you probably will not receive specialty provider information from the managed care plan. However, if you are at risk, you should develop profiles for each specialist provider to whom you refer and obtain the information below. Is the data in **Table 14(b)** available from the managed care plan(s)?

Table 14(b). Individual Specialty Care Utilization Provider Profile

		Data Provided By		*Data Available to Health Center*		
	Data Elements	Health Center	Managed Care Plan	Yes	No	Don't know
SPECIALTY CARE	Total visits		✓	❑	❑	❑
	Total expenses		✓	❑	❑	❑
	Cost per specialist visit		✓	❑	❑	❑
	Number of visits/1000 primary care patients		✓	❑	❑	❑
ANCILLARY	Number of paid ancillary referrals		✓	❑	❑	❑
	Total ancillary expenses		✓	❑	❑	❑
	Cost per ancillary referral		✓	❑	❑	❑
HOSPITAL *	Number of admissions		✓	❑	❑	❑
	Number of inpatient days		✓	❑	❑	❑
	Inpatient costs		✓	❑	❑	❑
	Average length of stay		✓	❑	❑	❑
	Cost per admission		✓	❑	❑	❑
	Number of emergency room visits		✓	❑	❑	❑

* *Admitted by specialty care provider*

ACTION PLAN

The fallawing changes are necessory in management infarmatian systems ta improve our ability ta manitar prepaid membership, capitatian, aggregate utilizotian and individual pravider utilizatian.

1. The fallawing staff members need training to imprave their ability ta analyze reparts, ta identify adverse trends and ta recammend carrective actian:

Staff	Training

CONTINUED ON NEXT PAGE

2. In the fallawing categaries, we need ta determine whether a) aur center ar the managed care plan can pravide the cited data element; and, b) if it can be provided, will it be made available ta us:

		Data Pravided By		Data Available ta Health Center		
Category	**Data Element**	Health Center	Managed Care Plan	Yes	No	Don't knaw
Membership		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
Capitation		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
Primary Care Aggregate Utilization		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
Specialty/Ancillary Aggregate Utilizatan		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
Inpatient Hospital Log		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
Individual Primary Provider		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
Individual Specialty Provider		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑

QUALITY ASSURANCE & UTILIZATION MANAGEMENT PLAN

Monitaring the quolity ond utilization of services rendered ta prepaid potients ond toking immediate corrective action when needed is of utmost impartance to o successful experience with manoged core. To accomplish this each heolth center must hove o Quolity Assuronce ond Utilizatian Manogement Plan (QA/UM). The breodth of the QA/UM Plan will be dependent upon the extent of financiol risk assumed by the center ond the policies ond procedures af the monoged core plon.

TO BE COMPLETED BY:

The Clinicol Director

	Yes	No
1 Does the health center have a written Quality Assurance and Utilization Management Plan which documents policies, procedures and protocols?	❑	❑
• Did the providers participate in the design of the plan?	❑	❑
• Did consumers participate in the design of the plan?	❑	❑
• Has the document been approved by the Board of Directors?	❑	❑
• Agree to cooperate with managed care plan's quality assurance activities?	❑	❑

	Yes	No
2 For those centers currently engaged in managed care, do you have the following policies and procedures:		
• A system for prior, written authorization for referrals to specialists and ancillary services?	❑	❑
• A system for prior, written authorization of inpatient admissions?	❑	❑
• A referral specialist log to track referrals?	❑	❑
• A daily hospital log of patients admitted and discharged from the hospital?	❑	❑
3 Does the Clinical Director meet with health center providers to discuss inappropriate utilization and cost patterns, i.e. hospitalization, referrals?	❑	❑
• Is there provider feedback to change provider patterns?	❑	❑
• Is the Clinical Director willing to enforce decisions in the event of inappropriate provider patterns?	❑	❑

	Yes	No
4 Are the following provider policies documented:		
• Physicians and mid-level practitioner credentials and state licensure are verified annually through primary sources.	❑	❑
• Physicians' credentials are maintained on the health center's premises and placed in public view.	❑	❑
• Physicians meet the following standards:		
Board Certification or candidacy for certification?	❑	❑
Current unencumbered state medical license(s)?	❑	❑
Proof of residency training?	❑	❑
Current DEA Certificate?	❑	❑
Current State Controlled Substance License?	❑	❑
Current and adequate malpractice coverage policy?	❑	❑
Meet continuing education requirements of the AMA, AOA, AAFP or other continuing medical education required by state law?	❑	❑
Not currently suspended or excluded from participating in Medicare, Medicaid, other health insurance programs?	❑	❑
Not suspended, limited or restricted from hospital staff privileges?	❑	❑

5 Managed care plans will often evaluate clinical staff proficiency prior to executing a contract. Do you regularly evaluate your clinical staff's proficiency in the procedures listed in **Table 15**?

Table 15. Evaluation of Clinical Staff Proficiency

Procedures	*Regular Evaluation*	
	Yes	No
EKG	❑	❑
Drawing blood	❑	❑
Immunizations	❑	❑
Tonometry	❑	❑
Audiometry	❑	❑
Visual Screening	❑	❑
Laceration repair	❑	❑
Routine GYN	❑	❑

6 Medical recard reviews may be canducted by managed core plans priar ta executing an agreement and may be undertaken periadically during the term af the cantract. Have the fallowing medical recard audits and standards been implemented and dacumented?

	Yes	No
• Recards are detailed, arganized, camprehensive, legible ond repraducible.	❑	❑
• Medical recards are shared amang praviders.	❑	❑
• Records are accessible ta praviders during affice hours.	❑	❑
• Recards are secured ta pratect patient canfidentiality.	❑	❑

7 Managed care plans are being requested to evaluate their performance against measures as defined under the Health Plan Employer Data and Information Set: Version 2.0 (HEDIS 2.0). Do you have guidelines to inform patients and evaluate outcomes for the HEDIS 2.0 performance measures listed in **Table 16**?

Table 16. HEDIS 2.0 Performance Measures

	Regular Evaluation	
Procedures	Yes	No
Childhood Immunization	❑	❑
Cholesterol Screening	❑	❑
Mammography Screening	❑	❑
Pap Smears for Cervical Cancer	❑	❑
Low Birth Weight	❑	❑
Prenatal Care in the First Trimester	❑	❑
Asthma Inpatient Admissions Rate	❑	❑
Diabetic Retinal Exam	❑	❑
Ambulatory Followup After Hospitalization for Major Affective Disorders	❑	❑

	Yes	No
Managed care plans will desire the health center be responsive to the needs of the prepaid plan members.		
• Do you have a system in place to monitor and respond to patient complaints?	❑	❑
• Do you monitor patient satisfaction on a regular basis through a survey?	❑	❑

ACTION PLAN

The fallawing actians are necessary ta improve aur quality assurance and utilizatian plan:

1. We need ta add the fallawing palicies ta our current QA/UM plan, i.e. pravider credentials, physician standards, autharizatians, specialist and haspital lags, etc.:

   _____

   _____

   _____.

2. Our clinical directar needs ta meet with the fallawing physicians regarding their practice patterns:

   _____

   _____

   _____.

3. The clinical staff's praficiency needs ta be evaluated regularly far the fallawing pracedures:

   _____

   _____

   _____.

4. Medical recard standards need ta be implemented in the fallawing areas:

   _____

   _____

   _____.

5. Guidelines far the fallawing HEDIS 2.0 Perfarmance Measures need ta be evaluated:

   _____

   _____

   _____.

6. Our patient camplaint pracedures need ta be revised in the fallawing ways:

   _____

   _____

   _____.

FACILITY

Managed care plans will evaluate the geagraphic lacatian af the health center(s) and the acceptability of the physical plant. Alsa, prospective enrollees will evaluate your facility as part af their decisian ta select yaur center as their primary care provider.

TO BE COMPLETED BY:

The Site Manager (If more than ane facility, camplete the following information far each site.)

1 Is the health center located in a geographic area which is:

	Yes	No
• Easily accessible to the majority of the target clients?	❑	❑
• In reasonable proximity to primary hospitals?	❑	❑

Source

Use the service area map you have prepared for the *Managed Care Market Area Self-Assessment Tool* (Section 1: Characteristics of Community Served). Within the service area note the location of the health center, key hospitals, major population centers by zip code and major transportation routes including public transportation.

2 Certain facility characteristics are important to the provision of care in a managed care environment. Does your health center meet the following guidelines:

Productivity and Efficiency

	Yes	No
• Is the total square footage equal to or greater than the number of FTE providers times 1000? If no, how much less square footage? _____	❑	❑
• Are there a minimum of two examination rooms per scheduled FTE provider? If no, how many per scheduled FTE provider?_____	❑	❑

	Yes	No
Patient Acceptability		
• During the health center's busiest days and times, do potients usually need to stand in the waiting room?	❑	❑
• Is the amount af time patients wait fram arriving at the health center until they see their pravider acceptable and reasonable?	❑	❑
• Is the waiting raom clean, uncluttered, safe and presentoble?	❑	❑
• Are the examinatian rooms clean, uncluttered, safe and presentoble and da they pravide patient privacy?	❑	❑
Licensing Issues		
• Is the health center hondicap-accessible?	❑	❑
• Did the health center pass the state facility licensing review?	❑	❑

ACTION PLAN

We need to make the following changes to our facility so it will be more acceptable to managed care plans and prospective enrollees.

1. Location

2. Size (square footage)

3. Number of examination rooms

4. Size of waiting room

5. Cleanliness of waiting room and examination rooms

6. Licensing

7. Other

CONCLUDING STRATEGIC QUESTIONS

Armed with the responses ond doto from the foregoing questions ond the resultont oction plon for eoch section, the members of the Boord of Directors ond senior monogement teom ore reody to evoluote the heolth center's reodiness to controct for monoged heolth core ond copocity to hondle risk in o monoged core setting. For those heolth centers olreody involved in monoged core, oreos for improvement con be identified and the potentiol for ossuming greoter risk or ossuming responsibility for more comprehensive services con be considered.

In oddition to the responses, doto ond oction plons, it is recommended the Boord ond monogement stoff consider the following key strotegic questions. The onswers to these questions together with the overoll evoluotion should provide sufficient informotion on which to bose your decision to enter the monoged heolth core morket or to strengthen your current involvement in this morket.

TO BE COMPLETED BY:

The Boord of Directors ond Senior Monogement

	Yes	No
1 Is it necessary to be competitive in your health care market to ensure the long term viability of your health center?	❑	❑
2 Do you have the physical and medical capacity to accommodate the prepaid patients projected in your market forecast, including fee-for-service conversions and new patients?	❑	❑
3 Will your administrative and medical staff cooperate to develop a coordinated health care delivery system?	❑	❑
4 If you plan to be at risk for primary, specialty and other medical services, can you arrange for a comprehensive scope of medical services independently or as part of an integrated network?	❑	❑
5 If you plan to be at risk for the primary, specialty and/or other medical services, do you have direct management and fiscal control over these services?	❑	❑
6 Are there one or more hospitals in the service area willing to work with you, to grant admitting privileges to your physicians and to cooperate in the management of the utilization, cost and quality of inpatient, outpatient and emergency services?	❑	❑
7 Are you interested in and capable of actively marketing your center to existing patients and potential enrollees in the service area?	❑	❑
8 Should you engage in managed care to protect your existing patient population and attract new patients?	❑	❑

	Yes	No
9 Da yau have a written, lang-range plan that includes a managed care strategy and alsa supports yaur missian?	❑	❑
10 Was the lang range plan appraved by the Baard af Directars and, if applicable, by the parent arganizatian ar affiliated entity?	❑	❑

Appendix 1

Managed Care Glossary

Accrual — The amount of money that is set aside to cover expenses. The accrual is the plan's best estimate of what those expenses are, and (for medical expenses) is based on a combination of data from the authorization system, the claims system, the lag studies and the center's prior history.

Actual Charge — The amount a physician or other practitioner actually bills a patient for a particular medical service or procedure. The actual charge may differ from the customary, prevailing, and/or reasonable charges under Medicare and other insurance programs.

Actuary — In insurance, a person trained in statistics, accounting, and mathematics who determines policy rates, reserves, and dividends by deciding what assumption should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earning, if any, expenses and persistency rates) and who endeavors to secure as valid statistics as possible on which to base these assumptions.

Admissions Per Thousand — The prevalent method of describing the hospitalization rates for a managed care population. It is expressed as: (# of admissions/member months) x 1,000 members x # of months.

Average Daily Census — The average number of hospital or health institution inpatients (other than newborns) each day throughout a given period. The census is calculated by dividing the number of patient days during a period by the number of calendar days in the period.

Average Length Of Stay — Average number of patient days of service rendered to each inpatient (excluding newborns) during a given period.

Benefit Package — A set of services specifically defined by an insurance policy or health maintenance organization that can be provided to patients.

Board Certified — A physician or other health professional who has been certified by a specialty board as a specialist in a given subject.

Board Eligible — A physician or other health professional who has met requirements for specialty board examination (including those who may have failed the examination, if they remain eligible).

Capitation — Payment based on an amount per person for providing services according to a defined set of benefits. Often used by HMOs to charge employer groups and, in turn, to pay providers, usually primary care physicians but at times specialists and occasionally hospitals. Since the monthly capitation amount is fixed for a given period of time (usually a year), costs to enrollees (or employers) do not change, nor do payments to providers.

Case Management — A process and technique to manage the care of specific health care needs (often multiple) in such a way that it is designed to achieve the optimum patient outcome in the most cost effective manner.

Concurrent Review — The process by which health services are reviewed to determine appropriateness; the review is conducted at the same time the services are provided vs. retrospectively.

Coordination Of Benefits (COB) — A term used to designate the anti-duplication provision that limits benefits for multiple group health insurance in a particular case to 100 percent of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Copayment — An amount of money which the member pays directly to a provider at the time services are rendered and is intended to control utilization.

Current Procedural Terminology, 4th Edition (CPT-4) — A set of five-digit codes that apply to medical services delivered. Frequently used for billing.

Days Per Thousand -- A standard unit af measurement af utilizatian. Refers ta an annualized use af the haspital ar ather institutianal care. It is the number af haspital days that are used in a year for each thausand cavered lives. The farmula used ta calculate days per thausand is as fallaws: (days/member manths) x 1,000 members x af # manths.

Deductiible — Cash payments that must be paid by the member befare insurance caverage begins.

Diagnastic Related Groups — A classificatian system that categarizes patients based an demographics, diagnasis, and therapeutic characteristics. Used ta predict medical services, average length af haspitalizatian and reimbursement. Originally develaped ta determine haspital payment rates far Medicare patients, DRGs have since been adapted by ather payars. Haspitals are placed at risk since the system limits reimbursements far length of stay and resaurces which exceed thase prescribed by a given DRG.

Disallowance — When a payar declines ta poy far all ar port af a claim submitted far payment.

Discharges — The number af patients wha leave an overnight medical care facility per time periad — usually refers ta haspital inpatients, less aften ta extended care facility inpatients.

Disenrollment — The pracess af terminotian af caverage, either an o valuntary ar invaluntary basis.

DCFA 1500 — The standard pravidar billing farm develped by the Health Care Finacncing Administratian (HCFA).

Encaunter Data — Data relating ta treatment af service rendered by a pravider ta a patient, regardless af whether the pravider was remimbrsed on a capitated af fee far service basis. Used in determing the level af service.

Enrollment — Initial pracess whereby new individuals apply and are accepted as members af a managed care plan.

Fee Schedule — A listing af fees ar allawance far specified medical pracedures, which usually represents the maximum amaunts the pragram will pay far specified pracedures.

Gatekeeper — A term used ta refer ta a primary care

physician who manages the care of individual patients. The gatekeeper physician must approve or be informed of the use of services, including referrals, inpatient and outpatient procedures. The gatekeeper may be offered incentives to help ensure the use of the most medically appropriate yet cost effective services.

Health Plan Employer Data and Information Set (HEDIS) — A care set of measures by which employers can compare the value of their health care dollar across a variety of health care plans.

Incentives — Profit sharing arrangements offered by HMOs and managed care plans that permit sub-contractors and physicians to share in amounts earned from plan savings through reduced hospital and specialty referral usages. (NOTE: Federal fraud and abuse rules may affect the types of incentive plans that health center or physicians may enter into).

Incurred But Not Reported Claims (IBNR) — Claims for which a managed care organization will be financially responsible but have not been reported to the plan. Managed care organization must maintain funds in reserve to cover this liability.

Managed Care — The body of organizational, financial, management and clinical activities that are implemented by professionals and organizational entities that are at financial risk for the cost of medical services they provide and/or arrange for a defined patient population.

Managed Health Care Plan — An arrongement which integrotes finoncing ond monogement with the delivery of heolth core services to on enrolled popolotion. It employs or controcts with on orgonized system of providers which delivers services ond frequently shores finoncial risk.

Member Months — The totol of oll months thot eoch member wos covered. For exomple, if o plon had 10,000 members in Jonuory ond 12,000 members in Februory the totol member months for the year-to-dote os of Morch 1 would be 22,000.

Outcome Measurement — A process of systemoticolly meosuring o potient's clinicol treotment ond response to thot treotment.

Patient Days — Accumuloted totol for o specific period of time of the number of potients in o hospitol eoch doy (excluding newborns). A potient doy is oone potient in on e hospitol bed for one doy.

Participating or Preferred Provider — A heolth services provider thot hos entered into o controctuol relotionship with o heolth plon to provide services to members.

Prepaid Capitation — A prospectively paid, fixed, onnuol, quorterly, or monthly premium per person or per fomily which covers o specified set of comprehensive benefits. A cost containment olternotive to fee-for-service usuolly employed by HMOs.

Per Member Per Month or Per Year (PMPM or PMPY) — Applies to o revenue or cost for each enrolled member eoch month or eoch yeor.

Primary Care — First-level, outpotient, medicol services os opposed to services such os routine surgery, e.g., gollstones (secondory core), or complex medicol services ond procedures, e.g., heort tronsplonts (tertiory core). Primory core is olso sometimes defined by the physicion speciolties involved. It usuolly includes fomily or generol proctice, pediotrics, obstetrics/gynecology ond internol medicine.

Prior Authorization — A formal process requiring a provider to obtain, in advance, approval to provide particular services or procedures. Generally, prior authorization is required for non-emergent services that are expensive or are likely to be abused or overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be compensated. Managed care organizations will collect prior authorization data to determine the extent of their financial responsibilities. (See *Incurred But Not Reported Claims*.)

Quality Assurance — A formal methodology and set of activities designed to assess the quality of services provided. Quality assurance includes a formal review of care, problem identification and corrective actions to remedy any deficiencies, and evaluation of actions taken.

Referral — A formal practice of sending a patient to another practitioner or facility for services or consultation that the referring source is not prepared or qualified to provide. Although the primary care physician may not provide the service, an at-risk primary care physician retains at least some responsibility for patient care after a referral has been made.

Retrospective Review — Determining the medical necessity of service after the service is provided. The review is conducted based upon an agreed set of practice guidelines to assist in determining medical necessity.

Risk Sharing — A provision of most prepaid health care plans where at least part of the provider's income is directly linked to the financial performance of the plan. If the plan's costs exceed its budget, the providers are responsible for covering at least part of the deficit.

Utilization Assumptions — Projected number of units of service (i.e. encounters, procedures, inpatient days or admissions, prescriptions, etc.) to be rendered to an enrollee or patient in o given period of time (usually one year).

Utilization Management (UM) — The process of evaluating the necessity, appropriateness, and efficiency of health care service against established guidelines and criteria.

Utilization Review (UR) — A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent, or retrospective basis.

Appendix 2

Resource Material

* *A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States (1993)* HCFA

* *A Manual for Negotiating with Managed Care Plans,* Contract No. 240-90-0501 (May, 1991) BHCDA

* *Critical Performance Measures for Prepayment, Community and Migrant Health Centers* (June, 1989) BHCDA

* *Financial Management Systems for Prepaid Program,* U.S. Department of Health and Human Services, DHS, HRSA, PHS

Health Plan Employer Data and Information Set ***(HEDIS 2.0)*** (1991) The National Committee for Quality Assurance, 1350 New York Avenue, Suite 700, Washington, DC 20005

Managed Care Standards Manual, The Joint Commission on Accreditation of Healthcare Organizations, 875 N. Michigan Ave., Chicago, IL 60611

Managed Health Care Directory, American Managed Care and Review Association, 1200 19th Street, NW, Suite 200, Washington, DC 20036

National Directory of HMOs, Group Health Association of America, 1129 20th Street, NW, Suite 600, Washington, DC 20036

Preparing for Prepaid Health Services—A Challenge for Community Health Centers, Contract No. 240-84-0117 (August, 1986) BHCDA

Standards for the Accreditation of Managed Care Organizations (1993) The National Committee for Quality Assurance, 1350 New York Avenue, Suite 700, Washington, DC 20005

* Available from:

The National Clearinghouse for Primary Care Information
8201 Greensboro Drive, Suite 600
McLean, VA 22102

For further reference and resource information, see **Managed Care Market Area Self-Assessment Tool,** *Appendix 2: List of State, Regional and National Organizations.*

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